E. coli O157:H7 Investigation Form

Arizona Department of Health Services

State I.D. Number:_____

****Please attach Communicable Disease Report (CDR) to this form****

Reporting State: _____ County:_____

I. DEMOGRAPHIC INFORMATION

1. Name-Last First

2. Date of Birth: _____/_____/_____ or Age: _____ years _____ months
mo day yr

II. ISOLATE INFORMATION

3. Source of Specimen: Stool (whole, stool swab, rectal swab)
Other (specify): _____
Not Isolated
Unknown

4. Date of Specimen Collection: _____/_____/_____
mo day yr

8. This case reported by:
Hospital lab State Lab
Other lab Other (specify): _____
Physician
Infection Control Practitioner
School

5. Was identification of the O157 serogroup confirmed, either at the State
Public Health Laboratory or at the Centers for Disease Control?
Yes No Unknown

Reporting laboratorian's name: _____

Telephone: ( ) _____ - _____

6. Was identification of the H7 serotype confirmed, either at the State Public
Health Laboratory or at the Centers for Disease Control?
Yes No Unknown

Physician's name: _____

Telephone: ( ) _____ - _____

7. Was Shiga-like toxin production confirmed, either at the State Public Health Laboratory or at the Centers for Disease Control?
Yes No Unknown

III. CLINICAL INFORMATION

9. Date of Illness Onset: _____/_____/_____ Unknown
mo day yr

10. Did the patient have: (please check one answer for each uestion)
Yes No Unknown

Diarrhea
Vomiting
Visible blood in stools
Fever (or felt feverish)
Abdominal cramps

11. Was the patient admitted overnight to a hospital for this illness?
Yes No Unknown
if yes, name of hospital:

12. Was the patient treated with antibiotics?
Yes No Unknown
if yes, name and dose: _____

13. Did the patient: (please check one answer for each question)
Yes No Unknown

have Hemolytic Uremic Syndrome?
(i.e. hemolytic anemia, low platelet count, kidney impairment):

have Thrombotic Thrombocytopenic Purpura?
(i.e. hemolytic anemia, low platelet count, kidney impairment, central nervous system involvement, fever):

undergo dialysis?

have surgery?

die?

IV. PUBLIC HEALTH INFORMATION

14. Does the patient attend or work in:
Yes No Unknown
a child day care center?
an institution?

if yes, where: _____

15. Is the patient usually employed as:
Yes No Unknown
a health care worker?
a food handler?

if yes, where: _____

V. DATA COLLECTOR INFORMATION

Person Completing This Form: Agency: Phone Number: Date: _____/_____/_____
mo day yr
( ) _____ - _____

***Note: If patient was hospitalized, please attach copy of discharge summary if possible.**

VI. EPIDEMIOLOGIC INFORMATION

16. In the 7 days before the illness began, did the patient eat at:

	Yes	No	Unknown
a fast food restaurant?			
another restaurant?			

if yes, name and location of restaurant(s)

_____
_____
_____
_____
_____
_____
_____

17. In the 7 days before the illness began, did the patient eat or drink any of the following items at home, in a restaurant, or in any other place?

	Yes	No	Unknown
raw (unpasteurized) milk			
other dairy products made from raw (unpasteurized) milk			
well water			
other unchlorinated water			
apple cider			
any ground beef or hamburger			
pink or red ground beef or hamburger			
any steak or roast beef			
pink or red steak or roast beef			

if yes, please list brand names and location where purchased:

_____
_____
_____
_____

22. In the 7 days before the illness began, did the patient:

	Yes	No	Unknown
visit or live on a farm?			
have contact with any cows or cattle?			
touch any cow manure?			
have contact with any children who attend a day care center?			
change any diapers?			
have contact with any children who use diapers?			
go swimming?			

if yes, where? _____

travel to another state?

if yes, where? _____

travel to another country?

if yes, where? _____

From? _____/_____/_____ to _____/_____/_____

23. Did anyone else in the patient's home have diarrhea in the 7 days before or after this patient's illness began?

Yes No Unknown

if yes, please obtain the following information on these people:

Name	Age	Sex	Bloody Stools? Yes	No	Unknown
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			

24. Does the patient know anyone else who has had a similar illness in the past 3 weeks? Yes No Unknown

if yes, please obtain names and telephone numbers of persons with similar illnesses: _____
_____
_____

25. Did this case occur as part of an outbreak (two or more cases of *coli* O157:H7 infection associated by time and place)?

Yes No Unknown

if yes, please describe: _____
_____
_____

Send or Fax to:
ADHS Infectious Disease Epidemiology
150 North 18th Ave, Suite 140
Phoenix, Arizona 85007-3237
(602) 364-3676
(602) 364-3199 Fax